

Patient Information

Today's Date: _____



How Did you hear about us? (Circle One):

Newspaper Internet Phone Book Family Doctor Friend Family Other (Please Explain): _____

Legal First Name	Middle Name	Legal Last Name	Date of Birth

<input type="radio"/> Single <input type="radio"/> Married	<input type="radio"/> Female <input type="radio"/> Male	
<input type="radio"/> Divorced <input type="radio"/> Widowed		
Marital Status	Gender	Social Security #

Street Address	City	State & Zip Code	Home Phone	Cell/Work

SPOUSE INFORMATION

Legal First Name	Middle Name	Legal Last Name	Date of Birth	Social Security #

Name of Family Doctor: _____ Referring Doctor: _____

Emergency Contact Name, Number & Relationship: _____

IF PATIENT IS A MINOR

Name of Father: _____ Name of Mother: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

Social Security#: _____ Social Security#: _____

Date of Birth: _____ Date of Birth: _____

MEDICAL RECORDS RELEASE

I authorize ENT Clinic, P.C. 515 Mulholland St., Bay City, MI 48708.

PHONE: 989-892-3541, **FAX:** 989-892-8285 to obtain any and/or all medical records on my behalf.

Printed Patient Name: _____

Signature of Patient/Parent/Guardian: _____

This document will remain in effect until revoked by me in writing